CONTRIBUTION TO THE KNOWLEDGE OF THE REFRACTIVE CONDITION OF THE EYES OF INFANTS AND YOUNG CHILDREN.

GERMAN'S investigations (*Arch. of Ophthal.*, xxxi. 2) are based upon an examination of the eyes of 110 children, from birth to three months old. He found that the eye of the nursing infant is strongly hypermetropic, but that the hypermetropia steadily diminishes with advancing age; in other words, that the eye gradually changes with its growth from a weaker to a stronger refraction. Hence the physiological refractive condition is that of the hypermetrope.

CONGENITAL COMPLETE PARALYSIS OF THE MUSCLES SUPPLIED BY THE MOTOR OCULI NERVE, WITH THE EXCEPTION OF THE IRIDES AND CILIARY MUSCLES.

TILLEY reports (*Amer. Journ. of Ophthal.*, Sept. 1885) a case of this kind in a boy, aged twelve, of normal mental and physical development, with no family history to account for the condition. The appearance, attitude, and gait of the patient were pathognomonic of the defect. The divergence of the axes of the eyeballs was so great, that double vision was absent throughout the extent of the visual fields. An examination of the vision showed: R. E., $\frac{6}{\mathrm{XXXVI}}$; L. E., $\frac{6}{6}$, and no improvement by glasses. He could read Sn. 0.8 at 6 inches with either eye. The color-sense was normal. There was complete absence of the patellar tendon reflex. Tilley thought that the seat of the lesion was in the cerebral substance, a view somewhat strengthened in his mind by the diminution of visual acuity. It is difficult to understand, on this hypothesis, how the fibres supplying the irides and ciliary muscles should have escaped. It is possible that the abducens nerve may have supplied the motor fibres.

TENOTOMY OF THE INFERIOR OBLIQUE MUSCLE.

LANDOLT describes (*Arch. d'ophthal.*, Sept.–Oct. 1885) his method of operating for tenotomy of the inferior oblique as follows: After fixing the skin on a level with that part of the inferior orbital margin which corresponds to the insertion of the muscle, a short, deep incision is made through skin and orbicular muscle down to the inferior margin of the orbit. After arresting the hemorrhage by aseptic iced applications, the lips of the incision are separated by hooks, and the wound examined for the tendon of the muscle, which is recognized by its color and the oblique direction of its fibres. The muscle is then seized with forceps or by means of the strabotomy-hook, and divided with either scissors or bistoury. The wound is then closed by a single suture. The course and insertion of this muscle probably exert some influence in the production of a venous stasis in the uveal tract, for beneath it may be always found one of the vasa vorticosa. This is of some importance in connection with one of the theories as to the production of progressive myopia.

A CASE OF PERIODIC PARALYSIS OF THE OCULOMOTORIUS.

MANZ (*Berl. klin. Woch.*, Oct. 5, 1885) prefaces a very detailed account of a case of this kind, occurring in his own practice, with a brief *résumé* of the cases hitherto published by Weiss, Thomsen, Remak, and others. The case which he has himself so carefully described, occurred in a young man, age not given, who had complete paralysis of all the branches of the right third nerve, with vision in the right eye of $\frac{4}{\text{VI}}$ and a hypmetropia of D. 0.25; the left eye being normal in all its functions. There was very marked limitation of accommodation and a boring pain in the orbit behind the eye. He had suffered from right hemicrania or migraine from his earliest childhood, but the first occurrence of the paralysis was in his fourteenth year, following a severe attack of hemicrania. Since then the paralysis has occurred at intervals of four or six weeks, and was always preceded by the hemicrania, which grew less and gradually disappeared after the occurrence of the paralysis. The duration of the latter varied from a day to several weeks. There was never any disturbance in the other motor or sensory nerves. In the intervals of the paralysis there remained a somewhat dilated pupil and a slight divergence of the eye. The patient was otherwise perfectly healthy, and had always been so. Abuse of alcoholics always brought on the paralysis. The case in some respects resembled one of migraine, but, on closer examination, it will be seen that each attack was simply an exacerbation of an existing diseased condition, due either to a local extension of the focus of disease, or to an increase in the degree of paralysis from compression of the nerve-fibres. Accompanying the lesion there might be either a transient cerebral hyperæmia or cerebral anæmia. If the paralysis be of central origin, we must locate the lesion in that region of the brain in which the nuclei of origin of the branches of the third nerve are found, stretching from the third ventricle backward through the aqueduct of Sylvius; a so-called nuclear paralysis. If the paralysis be peripheral, we must search for the focus of disease somewhere in the nerve-trunk between its point of exit at the anterior border of the pons and its entrance into the wall of the cavernous sinus. The unilateral character points to a peripheral origin of the disease. Our knowledge of the anatomical changes in recurrent paralysis of the oculomotorius also points to a peripheral origin, a disease of the nerve-trunk itself. No positive opinion can be formed as to the location of the lesion in these cases, but an additional point in favor of the peripheral origin of the disease lies in the fact that no one has as yet furnished proof of the existence of an intracerebral lesion as the cause of an isolated paralysis of a single branch of the third nerve on one side.

A CASE OF ABSCESS OF THE ORBIT; TOTAL BLINDNESS; ATROPHY OF THE DISK AND OBLITERATION OF THE RETINAL VESSELS, FOLLOWING AN UNSUCCESSFUL ATTEMPT TO EXTRACT THE UPPER CANINE TOOTH.

BURNETT reports (*Arch. of Ophthal.*, xiv. 2 and 3) an interesting case of great swelling of the eyelids and face, following an unsuccessful attempt to extract the upper canine tooth, in a negro, aged 35. Burnett saw the case four months later, when the eye was in proper position and its motility perfect. There was a depression at the outer part of the lower orbital ridge, extending four-fifths of an inch downward into the cheek, caused by exfoliation of bone. There had undoubtedly been an abscess of the maxillary antrum, caused by a fracture of its walls from the forcible but unsuccessful